Plan of Correction Approved 5/9/19 SHN

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (i) General (6).

1. *Based on clinical record reviews, interviews, policy review and review of contracted services, the hospital failed to ensure that contracted physicians (Hospitalists) provided quality care to one of three patients (Patient #44) who had critical laboratory results. The findings include the following:
   a. Patient # 44 was admitted on 1/7/19 with generalized weakness and new onset diarrhea and vomiting. Review of the History & Physical (H&P) dated 1/7/19 indicated that the patient had a three day history of low back pain and abdominal cramps. Laboratory blood work was obtained that indicated a white blood count of 12.5 (normal 4.0-10.5), BUN of 42 (normal 6.0-20.0) and creatinine of 1.4 (normal 0.7-1.2). The H&P indicated that the patient had severe weakness which could be attributed to severe dehydration, and acute gastroenteritis. Blood cultures times 2 were obtained on 1/7/19 at 11:48 AM and 12:36 PM. The record indicated that on 1/8/19 at 1:05 AM laboratory staff called the Charge Nurse with a critical report that identified the patient's blood culture was positive with gram stain which was suggestive of Gram Positive Cocci. The clinical record indicated that RN #4 notified MD #4 at 1:13 AM, the note indicated that MD #4 was made aware and he indicated that he would like to be notified if the patient's temperature was greater than 100.4 and made no changes to the patient's treatment. The record indicated that the Charge Nurse was called on 1/8/19 at 1:31 AM and was notified that the second blood culture was positive with the gram stain which was suggestive of Gram Positive Cocci.
      Interview with RN #4 on 1/31/19 at 8:40 AM indicated that she did not call the physician regarding the second blood culture because she felt that when she notified MD #4 earlier he indicated that he was to be called if the patients temperature was greater than 100.4 and at that time the patients temperature was 98.7.
   b. Review of Patient #44's clinical record failed to identify that MD #4 documented the results of the preliminary blood culture results and/or his rationale for not initiating additional treatment.
      Interview with MD #4 on 2/4/19 at 9:00 AM indicated that he did not receive a sign off from the day shift hospitalist regarding Patient #44 and had to rely on what he was told by nursing and a review of the case on the computer. MD #4 indicated that he was notified of the positive blood culture and informed the RN to notify him if the patient's temperature elevated, however he did not write a note and/or pass this information on to the oncoming shift. MD #4 indicated that even if informed of the second positive blood culture he would not have initiated antibiotics since the results were preliminary and could have been contaminants. MD #4 stated that for anything critical or actionable he would get in touch with the oncoming provider. MD#4 indicated he is responsible for "70-75 patients on the night shift" and "I just report actionable items". MD #4 indicated there were "far more sicker patients" in the hospital that night. MD #4 indicated that the on-coming day shift hospitalist should be reviewing all information that occurred overnight when rounding on

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the patient.

c. Review of Patient #44's clinical record identified that MD #3's progress note dated 1/8/19 at 10:30 AM failed to reflect that he reviewed all the laboratory data since the previous day and/or that he was aware of the positive blood cultures.
Interview with MD #3 on 1/31/19 at 9:00 AM indicated that he was Patient #44's primary hospitalist and is the Medical Director of the hospitalist program. MD #3 indicated that he would have expected MD #4 to document a note in the record regarding the positive blood cultures. MD #3 stated that in his opinion antibiotics should have been started when the first positive blood culture came back. In addition, MD #3 indicated that in the morning (1/8/19) he did not receive a sign out from MD #4 informing him of the positive blood culture, which resulted in antibiotics not being started. MD #3 indicated that the hospitalist program is a contracted service that had started at the hospital on 1/1/19. MD #3 indicated that the lack of a physician signout process is a weakness that he will be addressing.

d. A nurse's note dated 1/9/19 at 3:34 AM indicated that on 1/8/19 at 10:52 PM Patient #44 was noted to have a temperature of 102.2, pulse of 102 and an oxygen saturation of 84%. A rapid response was called resulting in the intubation and mechanical ventilation of the patient. Zosyn and Vancomycin were administered at approximately 11:30 PM and the patient was transferred to the ICU. Despite life saving measures, Patient #44 expired on 1/9/19 at 12:55 AM.
A discharge summary dated 1/9/19 identified Patient #44's discharge diagnosis as viral myositis.
Interview with the President of Medical Affairs on 2/15/19 stated that the hospitalist group is a contracted service and the Medical Director of the hospitalist program (MD#3) is responsible for staffing based on patient census. The President stated a change in the patient's medical status should be documented in the clinical record.
Review of the contracted programs guidelines indicated in part that hospitalist physicians and providers will abide by the hospitals guidelines for completion of timely documentation for clinical communication and administration services. The guidelines indicated that hospitalist communication with other providers shall have the goal of maintaining continuity of care through the patient's hospital stay.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2).

2. *Based on review of the hospital's QAPI program, associated documentation and staff interviews, the hospital failed to develop and implement performance measures to include patient safety on the geriatric psychiatric (geri-psych) behavioral health unit. The finding includes:
   a. Review of the hospital's QAPI program identified that hospital wide performance measures include patient falls, restraint usage and assaultive behaviors. The data collected through performance measures demonstrated that the data was being analyzed, tracked, and included ongoing reviews of the performance measures. However, the geri-psych behavioral health patients were not included in the data collection.

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The hospital's QAPI program was reviewed with Quality Specialists # 1 and # 2 on 2/25/19 at 11:50 AM. The QAPI program failed to include patient safety measures specific to the geri-psych behavioral unit to include previously identified safety concerns with fall risk assessments, the use of the seclusion room, safety monitoring and/or implementation of interventions to maintain patient safety.
Although the hospital discussed fall risk patients at a hospital wide safety huddle and education was to be completed with staff regarding the use of 4 point restraints versus seclusion, the hospital failed to analyze the data gathered in the assessments or evaluate the effectiveness of patient safety interventions for patients identified as high fall risk on the geri-psych behavioral health unit.

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3. *Based on clinical record reviews, interviews and policy review for three (3) of six (6) patients who underwent invasive procedures (Patients #3, #4 and #7), the hospital failed to ensure that the invasive procedures were completed on the correct location of the body and/or failed to ensure the correct procedure was performed. The findings include the following:
   a. Patient #3 was admitted on 10/18/18 for a right sacroiliac and right greater trochanteric bursa injection under fluoroscopy. The consent was completed on 10/11/18. Review of the record identified that the patient went to the OR at 2:30 PM and the procedure was completed at 2:36 PM.
   Review of the operative note dictated on 10/18/18 at 2:06 PM with an addendum dated 10/18/18 at 4:34 PM identified that the patient's right ischial bursa was injected, not the right greater trochanteric as was intended.
   Interview with MD #6 on 1/31/19 at 12:00 PM stated during the timeout procedure the nurse was holding the consent, the procedure was read out loud and the patient pointed to the area. MD #6 indicated that the patient was marked for laterality but not for the specific site.
   Review of the Universal protocol indicated that site markings are required for all procedures involving distinction between sides, surface, multiple structures, or multiple levels. Site markings are the licensed independent practitioner's initials. The time out addresses, in part, the correct patient identity, confirmation that the correct side and site are marked, an accurate procedure consent form, agreement on the procedure being done and correct position.
   b. Patient #4 was admitted on 9/14/18 with a right meniscus tear. Review of the consent form dated 8/27/18 identified a right knee arthroscopy with possible lateral meniscus repair. The H&P completed on 8/27/18 with an addendum on 9/11/18 indicated the plan was to repair the right medial meniscus.
   Pre-operative documentation indicated that the RN Circulator prepped the right knee and the timeout was completed on 9/14/18 at 1:52 PM. Review of the operative report indicated that a left knee medial and lateral meniscus tear was repaired.
   Interview with the RN Circulator on 1/31/19 at 1:15 PM indicated when he looked at the schedule he thought it was a left knee procedure and that the left leg was prepped in error

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prior to the procedure.
Interview with MD #5 on 1/31/19 at 10:40 AM indicated that he saw the patient in the pre-operative area and initialed the right leg. MD #5 indicated that upon arrival to the OR the patient was in position, the leg was prepped and draped, and the timeout identified that the "appropriate" procedure was being done. MD #5 identified that he did not have the consent in front of him during the "time out".

c. Patient (P) #7 was admitted to the Interventional Radiology (IR) department on 4/13/18. An original order dated 4/2/18 and signed by the ordering physician indicated P#7 was to have a CT scan of his/her left sternoclavicular (SC) joint. Review of the electronic order generated by Scheduler #1 dated 4/2/18 at 1:00 PM indicated P#7 was to undergo a CT scan of the sacroiliac (SI) joint with injection.
According to a procedure note dated 4/13/18 by Interventional Radiologist (IR) #1, P#7 had been initially scheduled for a left SI joint injection however the original order had been brought to IR#1's attention prior to the patient's arrival because the original order from the ordering physician's office stated SC joint not SI joint. The ordering physician's office was subsequently contacted by Radiology Technician (RT) #1 and the office confirmed that the left SC joint was the correct site.
According to the procedure Universal Checklist completed by RT #1 on 4/13/18, P#7 confirmed the procedure as a left SC joint injection, the consent dated 4/13/18 was signed by P#7 for a left SC joint injection and the left SC joint site was verified and marked by IR #1. In addition a "time out" had been completed prior to the start of the procedure and P#7 agreed the procedure was a steroid injection to the left shoulder.
On 4/13/18 at 12:00 PM P#7 received an injection of Depomedrol and Sensorcaine to the SC joint administered under ultrasound guidance. After P#7 was discharged it was discovered that P#7 should have undergone a CT scan of the left SC joint not an injection. The ordering physician's office and P#7 were notified of the error and P#7 returned to the hospital for a left SC joint CT scan on 4/13/18.
During an interview with RT #1 on 2/27/18 at 11:30 AM he/she indicated prior to the procedure he/she compared the original order, which indicated SC joint with the order entered in the system, which indicated SI joint. Prior to the procedure he/she called the ordering physician's office and clarified if the "injection" was in the SC joint and not the SI joint. The ordering physician's office confirmed a SC joint injection.
During an interview with IR#1 on 2/27/19 at 11:40 AM, IR#1 indicated he/she did visualize the written order and saw SC joint identified however he/she did not see that CT scan was also indicated. IR#1 indicated based on P#1 verifying the SC joint injection several times prior to the procedure and the history P#1 presented with of SC joint pain and swelling with arthritis IR#1 felt the procedure was not out of the ordinary therefore he/she did not question the injection. IR#1 indicated shortly after the injection the ordering physician's office called looking for the CT scan results and that was when the error was identified.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B).

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4. *Based on clinical record reviews, policy review and interviews for one (1) of four (4) patients who underwent a procedure (Patient #4), the hospital failed to ensure that physician's followed medical staff bylaws and/or policies. The findings includes the following:
   a. Patient #4 was admitted on 9/14/18 with a right meniscus tear. Review of the consent form dated 8/27/18 identified a right knee arthroscopy with possible lateral meniscus repair. The H&P completed on 8/27/18 with an addendum on 9/11/18 indicated the plan was to repair the right medial meniscus. Pre-operative documentation indicated that the RN Circulator prepped the right knee and the timeout was completed on 9/14/18 at 1:52 PM. Review of the operative report indicated that a left knee medial and lateral meniscus tear was repaired. MD #5 failed to amend the operative report following the identification of the error. Interview with MD #5 on 1/31/19 at 10:40 AM indicated that he did not find out until later in the recovery room about the error and was unsure of what to do and did not document the error in the operative report.
   b. Review of Patient #4's clinical record indicated that a consent was completed on 9/14/18 for a right knee cortisone injection. The consent failed to reflect the time it was obtained. Review of the Medical Staff bylaws indicated that it is the responsibility of the practitioner to obtain proper informed consent as a prerequisite to any procedure or treatment. The hospital policy indicated when obtaining informed consent, the consent must contain the minimal element which are in part, date and time the informed consent is signed by the patient or legal representative, and the witness.
   c. Interview with MD #5 on 1/31/19 at 10:40 AM indicated that after it was discovered that the meniscus repair was completed on the incorrect knee, the decision was made to inject cortisone into the patient's right knee to help alleviate the patient's discomfort. Review of the clinical record with MD #5 failed to reflect documentation of the procedure. Review of the bylaws indicated that a brief operative/procedural report must be written in the medical record immediately following the conclusion of the surgery/procedure.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing Services (1) and/or (i) General (6).

5. *Based on a review of facility documentation, clinical records, staff interviews, and policy review, for two (2) of three (3) sampled patients reviewed for falls, the facility failed to ensure Patient #6, who required assistance with ambulation, was provided that assistance following administration of psychoactive medication and placement in a seclusion room, resulting in a fall with significant injury and/or for Patient #2, failed to remain with a patient identified as a high fall risk while the patient was standing resulting in a fall with injury. The findings include:
   a. Patient #6 was admitted to the inpatient geriatric psychiatric rehabilitation unit on 1/7/19 with agitation and behavioral disturbances including combative behaviors. A fall risk assessment dated 1/17/19 at 10:00 PM identified the patient was a high fall risk and safety interventions included assistance with ambulation and transfers, more frequent monitoring, and constant observation.
   Nurse's notes dated 1/17/19 into 1/18/19 identified that between 8:00 PM and 6:00 AM,

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Patient #6 was intermittently irritable and angry, anxious and restless, combative with care, hitting, elbowing and twisting staff arms and hands and climbing out of bed. Documented interventions identfied that the patient was ambulated in the hallways with assistance of 2 staff, and fluids, snacks and toileting were offered. In this timeframe, Patient #6 received Haldol 2 milligrams (mg) by mouth, and Haldol concentrate 1 mg by mouth with no effect. The physician was notified and directed to administer Haldol 2 mg IM and Ativan 1 mg IM, however the patient continued with verbal/physical aggression towards staff.

On 1/18/19 at 6:05 AM, Patient #6 was placed in a seclusion room with 1 to 1 monitoring with staff standing outside of the seclusion room door. Despite Patient #6 being identified as a high fall risk and requiring assistance with ambulation and transfers, there was no staff in the seclusion room with the patient to provide assistance with ambulation. A nurse's note at 6:55 AM identified the patient was kicking and hitting at the door and fell backwards landing on the floor and hitting his/her head on the wall. The patient was assessed and vital signs were obtained but was uncooperative with neurological checks. The patient was noted with redness to the occipital area of the head and a skin tear to the left elbow. The patient was transferred to a Geri-chair.

Review of a physician progress note dated 1/18/19 at 9:33AM identified a small bump on back of Patient #6's head. The note identified a CT scan will be ordered related to head trauma as the patient was at risk for intracranial hemorrhage given age and dementia.

Review of the CT scan report dated 1/18/19 identified multiple small bilateral hemorrhagic contusions.

Review of the MD progress note dated 1/18/19 at 12:32 PM identified that the CT scan was reviewed with a hospitalist who recommended either to transfer for neurological consult if family wished for aggressive treatment or transfer to medicine for observation and probable palliative care. The note further identified that education was provided to the family regarding the seriousness of the event and the likelihood of death with continued brain bleeding. Patient to be transferred to medicine floor and will request a Hospice consult.

Review of the clinical record identified that between 1/18/19 and 1/25/19, Patient #6 was identified as sedated, lethargic, sleeping, and/or unresponsive, and comfort measures continued to be provided. A physician progress note dated 1/25/19 at 11:43 AM identified Patient #6 was pronounced expired at 11:30 AM.

Interview with RN #4 on 2/5/19 at 11:00 AM stated that on the evening of 1/17/19 into the morning 1/18/19 Patient #6 was restless and agitated throughout the night and was placed on a 1 to 1 intermittently. RN #4 stated that the patient was medicated with his/her scheduled Haldol as well as administering the as needed (prn) Haldol around 3:00 AM for escalating behaviors and trying to climb out of bed. RN # stated the patient's behaviors escalated by grabbing, kicking and punching at staff and twisting a staff members arm, the physician was notified and the physician directed to administer Haldol and Ativan IM. RN #4 stated that she called the RN Supervisor to the floor who directed to place the patient into the seclusion room to calm the patient down with 1 to 1 monitoring outside the door. RN #4 stated that she was aware the patient required assistance with ambulation due to the patient having an unsteady gait. RN # stated that she was watching the patient on camera and observed the

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patient kicking and banging at the door and then fell backwards hitting his/her head on the wall. RN #4 stated that she went to the seclusion room and assessed the patient and notified the MD.

Interview with RN #6 on 2/8/19 at 8:35 AM stated that she was called to the unit due to the patient having increased behaviors, hitting and yelling at staff. RN #6 stated that she was aware the patient required assistance with ambulation and transfers but she did not want to place the patient in 4 point restraints because she felt it would be undignified and the day prior the patient was in the seclusion room and was fine. RN #6 further stated that she was unsure where the 4 point restraints were located and if they would be able to apply them because she wasn't sure security was on the floor.

Interview with Quality Specialist #1 on 2/5/19 at 11:15 AM stated that a patient who was requiring assistance for ambulation should not have been left alone in the seclusion room and that receiving Haldol placed the patient in even greater risk for falls. Quality Specialist #1 stated that there are other interventions that could have been used such as a Geri-chair and/or 4 point restraints until the patient's behaviors decreased.

Interview with MD #8 on 2/7/19 at 2:30 PM stated that he reviewed Patient #6's case and the patient's family declined to have a follow up CT scan to see if the bleed had changed. MD #8 stated that the family requested palliative care. MD #8 further stated that it would be hard to tell why the patient died without the follow up CT scan.

Review of the hospitals policy on Restraint and Seclusion identified the use of restraints or seclusion may occur in response to emergent, dangerous behaviors as an adjunct to maximizing a patient's safety and promoting their wellness.

Review of hospital Fall Prevention and Management Protocol identified a patient who is at high risk for falling staff are to assure assistance and stay with the patient during elimination, transfers and ambulation activities.

b. Patient #2 was admitted to the ED on 10/12/18 for increased difficulty swallowing, increased regurgitation and weakness. The patient was admitted for Intravenous (IV) fluids and possible esophageal manometry. Physician orders dated 10/12/18 directed to ambulate the patient with assistance. The fall risk assessment dated 10/25/18 at 12:00 AM identified Patient #2 as a high fall risk. Additional safety interventions included assistance with toileting, transferring and ambulation.

Review of a nurse's note dated 10/25/18 at 7:30 AM identified that at 5:25 AM Patient #2 was heard yelling for help and upon arrival to the room the patient stated he/she needed to get up. The note identified the nurse assisted the patient to the edge of the bed and then to a standing position and assisted the patient to use the urinal. Patient #2 became unsteady and stumbled to the left side. The RN's hands were around the patient's waist, and the patient was assisted to the ground landing on the left hip area. Patient #2 was assessed and complained of left hip pain. The note further identified the MD and RN Supervisor were called to assess the patient and an X-ray was obtained.

Review of the Diagnostic report dated 10/25/18 identified a left intertrochanteric fracture of the left proximal femur.

Review of facility documentation dated 12/25/18 identified as the RN assisted the patient to

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a standing position to use the urinal, the patient's bed alarm was alarming. The RN let go of the patient to turn off the alarm and the patient began to fall. The documentation further noted that the RN grabbed the patient by the waist in attempt to assist the patient to the floor.

Interview with Quality Specialist #2 on 2/7/19 at 1:15 PM stated that a patient who is a fall risk and requires assistance with ambulation and transferring is not to be left alone. Quality Specialist #2 stated that during the review of the fall, it was identified that the RN let go of the patient to turn off the bed alarm.

Several attempts to contact RN #7 were unsuccessful.

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6. Based on clinical record review, facility policy review and staff interview for one (1) of three (3) sampled patients reviewed for safety checks, (Patient #6) the facility failed to ensure that nursing staff monitored and/or accurately documented the patient's behaviors. The finding includes:
   a. Patient #6 was admitted to inpatient geriatric psychiatric rehabilitation on 1/7/19 with agitation and behavioral disturbances including combative behaviors.

      Review of Patient #6's Nursing Observation Sheet 15 minute Patient Safety Checks dated 1/17/19 identified that from 12:00 AM thru 5:45 AM the patient was in his/her room and/or hallway. In this timeframe, the patient's behaviors were documented as 1:1 (staff supervision), which was inconsistent with the pre-established list of patient behaviors to choose from. However, according to nursing notes, Patient #6 was placed in the seclusion room on 1/17/19 at 5:15 AM for behaviors of being very agitated, swatting and kicking at staff, exit seeking, yelling and resistive to care, which were not identified on the patient safety check sheet.

      According to nursing notes, Patient #6 remained in the seclusion room from 1/17/19 at 5:15 AM until 8:50 AM. Review of the Nursing Observation Sheet 15 minute Patient Safety Checks identified from 5:15 AM through 8:50 AM the patient was isolative with no behaviors identified.

      In addition, the Nursing Observation Sheet 15 minute Patient Safety Checks dated 1/17/19 from 9:00 AM through 5:30 PM identified the patient's behaviors as 1:1 (staff supervision), inconsistent with the pre-established list of patient behaviors to choose from.

      Review of the Nursing Observation Sheet 15 minute Patient Safety Checks dated 1/17/19 and Interview with Quality Specialist #1 on 2/5/19 at 12:30 PM identified that although the nurse's notes identified the patient was in the seclusion room from 5:15 AM until 8:50 AM, the documentation failed to identify the behaviors the patient was exhibiting during that time. The Quality Specialist stated that the behaviors need to be documented in order for nursing to determine if the intervention is appropriate.

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7. Based on clinical record review, interview and policy review for one (1) of three (3) patients reviewed for medication administration (Patient #12) the hospital failed to ensure that medications were administered as ordered and/or that the efficacy was assessed. The findings include the following:

   Patient #12 was admitted on 1/15/19 for a total knee replacement. Review of the physician's orders dated 1/14/19 directed Morphine 2 mg IV for severe pain (level 8-10), Oxycodone 5 mg for moderate pain (level 5-7), and Tramadol 50 mg for mild pain (level 1-4).

   a. Review of the clinical record on 1/16/19 at 1:30 PM with the Nurse Manager indicated that on 1/15/19 at 9:28 PM the patient indicated a pain level of 8 and 5 mg of Oxycodone was administered. The clinical record indicated that on 1/17/19 at 6:47 AM the patient had a pain level of 9 and 5 mg of Oxycodone was administered, instead of Morphine as directed in the physician order.
   b. Review of the clinical record indicated that on 1/17/19 Patient #12 had a pain level of 7 at 1:42 PM and 5 mg of Oxycodone was administered. The record failed to reflect an assessment to determine the efficacy of the medication.
   c. Review of the clinical record indicated that on 1/16/19 at 6:45 AM Patient #12 had a pain level of 7 and Tramadol 50 mg was administered instead of Oxycodone as directed in the physician's order.
   d. The clinical record indicated that on 1/15/19 at 1:18 PM the patient had a pain level of 7 and Tramadol 50 mg was administered instead of Oxycodone as directed in the physician's order. The record indicated that at 2:15 PM the patient's level of pain was reassessed and was again a 7. The record failed to reflect that this elevated level of pain was addressed and/or failed to identify the rationale of no further interventions.
   e. The clinical record indicated that on 1/16/19 at 8:20 AM and 6:45 PM the patient had a pain level of 7 and Tramadol 50 mg was administered instead of Oxycodone as directed in the physician order. The record indicated that at 10:45 AM and 8:00 PM the patient's level of pain was reassessed and was again a 7. The record failed to reflect that the elevated levels of pain was addressed and/or failed to identify the rationale of no further interventions.

   Review of the policy for Medication Administration indicated that patients will receive medications per the physician's order. The Pain Assessment policy indicated that it is the responsibility of all clinical staff to assess and reassess the patient for pain and for relief from pain.

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8. Based on facility documentation, clinical record review, staff interviews, and hospital policy, for three (3) of four (4) sampled patients reviewed for controlled substances, (Patient #33, #35 and #36) the hospital failed to ensure controlled substances were discarded appropriately. The

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findings include:

a. Patient #33 was admitted to the Emergency Department (ED) for flu like symptoms. Physician orders dated 2/25/18 at 11:12 PM directed to administer Morphine Sulfate 4 mg Intravenous (IV) now. Review of the medication dispensing system identified RN # 1 pulled Morphine 10 mg for Patient #33, but failed to document the time and who witnessed the remaining 6 mg of Morphine being discarded.

b. Patient #35 was admitted to ED on 2/25/18 with complaints of abdominal pain, cough and body aches. Physician orders dated 2/25/18 at 2:50 PM directed to administer Ativan 10mg IV now. Review of the medication dispensing system identified RN #1 pulled Ativan 2 mg vial at 2:43 PM and wasted 1 mg of Ativan at 5:52 PM without the benefit of a witness.

c. Patient #36 was admitted to the ED on 2/25/18 with complaints of left hip pain. Physician orders dated 2/25/18 at 2:26 PM directed to administer Dilaudid 10mg IV now. Review of the medication dispensing system identified RN #1 pulled Dilaudid 2 mg at 2:29 PM, but failed to document the time and who witnessed the other 1 mg of Dilaudid being discarded. Interview with the Director of Pharmacy on 2/5/19 at 1:45 PM stated discrepancy reports are generated from the pharmacy each day and on the report it identifies if mediations were wasted appropriately according to hospital policy. The Director of Pharmacy further stated that he reviews those reports and saw that RN #1 had pulled a larger amount of controlled medications then what was ordered but did not waste the medications with another nurse according to hospital policy.
Interview with Quality Specialist #1 on 2/7/19 at 10:15 AM stated that when controlled substances need to be wasted another nurse is to be present and the medication is to be put into the sharps container and the witness enters their password to complete the transaction. In the case of RN #1, this process did not occur.

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9. Based on a tour of the facility, review of facility policies, observations and interviews for one of three ST (scrub technicians), the facility failed to ensure proper hair coverage and/or a sanitized environment in the surgical suite. The finding includes:

a. A tour of the surgical areas was conducted on 1/17/19 with the OR Supervisor. Observation on 1/17/19 at 9:53 AM identified ST #1 next to the sterile field during
Patient #26's surgical eye procedure. Although ST #1 had donned a bouffant head covering, hair was observed sticking out from either side of the bouffant. Subsequently, the OR Manager entered OR #6 and assisted ST #1 in adjusting her bouffant. The facility policy for OR attire identified that hats and hoods should cover head and facial hair.

b. A tour of the surgical areas was conducted on 1/17/19 with the OR Supervisor. Observation of OR #3 at 9:34 AM noted a build-up of dust and debris on the horizontal surfaces of the wall hand sanitizer and the built-in wall radio. Interview with the OR Supervisor on 1/17/19 at 9: 48 AM indicated that the surgical suite is sanitized after each OR case by staff with the

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use of a germicidal wipe. The facility policy for OR terminal cleaning directed to damp wipe all horizontal surfaces with germicidal detergent.

10. Based on a tour of the facility, review of facility policies, observations and interviews for two of ten glucometer control solutions, the facility failed to ensure that the opened solutions were dated as per policy. The finding includes:

    a. A tour of the PACU (Post anesthesia care unit) was conducted with the PACU Manager on 1/17/19. Observations on 1/17/19 at 10:01 AM identified that the high and low control solution bottles for the glucometer were opened. The observation and interview with the PACU Manager further noted that although a date or dates had been previously hand written on the bottles, the writing was smudged and not discernable. The facility policy for glucose testing identified that glucose solutions are good for three months and the date the vial is opened and expiration date should be written on the vial label.

11. Based on a tour of the facility, review of facility policies, observations and interviews for two of three automated scope cleaners the facility failed to ensure that cleaning/maintenance was documented and/or performed as per policy.

    The finding includes:

    a. A tour of the endoscopy reprocessing area was conducted with the Lead Techician on 1/17/19. Observations on 1/17/19 at 12:47 PM identified that the facility had two scope machines (Olympus) that were connected to four blue water filters. A date on the whiteboard indicated that the four filters were changed last on 11/28/18. Interview with the Lead Technician on 1/17/19 at 12:47 PM and/or 1:03 PM noted that the date on the board was incorrect and, although a log was not maintained, the filters were last changed at the beginning of January. Further interview identified that she notifies the plumber that the filters need changing whenever her machine readings are high (approximately monthly). Interview with Plumber #1 on 1/17/19 at 12:50 PM indicated that he is notified of the need to change the water filters but could not provide documentation of when the filters were changed. Review of manufacturer's recommendations for the Olympus endoscope reprocessor identified that monthly maintenance included changing the water filters.

12. Based on a tour of the facility radiological services, review of facility policies, observations and interviews the facility failed to ensure that patient equipment was properly maintained/sanitized and/or had not expired. The finding includes:
    a. A tour of the three x-ray rooms was performed on 1/17/19 with the Director of Diagnostic

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Imaging. Observation of x-ray room #4 identified that the vinyl pad on the x-ray table had multiple tears around all edges exposing the foam beneath and rendering the equipment unable to be properly sanitized. Interview with the Senior Lead Technician of Diagnostics identified that a germicidal wipe was used to clean the x-ray room tables as in the OR. The facility policy for infection control and decontamination of the imaging equipment identified that imaging rooms and equipment are surfaced cleaned with a Hospital approved disinfectant and must be done after contact with every patient.

b. A tour of the IR (interventional radiology) room was conducted on 1/17/19 with the Lead IR Technician. Observation at 3:00 PM on 1/17/19 noted that 6 stents and 4 wires in the IR closet had expiration dates that ranged from 2011 to 2018. Interview with the Lead IR Techician at this time indicated that it was his responsibility to check the IR cabinet for outdated equipment. The facility job description for Lead Technologist identified a responsibility to maintain adequate inventory of all required supplies. The facility policy for general storage areas identified that shelf control shall be the responsibility of that department only.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (4) (A) and/or (d) Medical records (3) and/or (e) Nursing Services (1) and/or (i) General (6).

13. Based on a tour of the facility, review of medical records, review of facility policies and interviews for three of three patients who had dual endoscopic procedures (Patient #23, Patient #24 and Patient #25), the facility failed to ensure each procedure start and/or end time was documented. The finding includes:
    a. Patient #23 had both upper and lower endoscopic procedures performed at the facility on 1/11/19. The operative record identified 8:33 AM as the start of the procedure (upper endoscopy) and 9:14 AM as the end of the procedure (colonoscopy). Review of the end time of the upper endoscopy procedure and the beginning time of the colonoscopy procedure were not documented.
    b. Patient #24 had both upper and lower endoscopic procedures performed at the facility on 1/11/19. The operative record identified 12:40 PM as the start of the procedure (upper endoscopy). 12: 53 PM as the start time of the colonoscopy and 1:05 PM as the end of the colonoscopy procedure. Review of the end time of the upper endoscopy procedure was not documented.
    c. Patient #25 had both upper and lower endoscopic procedures performed at the facility on 1/7/19. The operative record identified 9:58 AM as the start of the procedure (upper endoscopy) and 10:42 AM as the end of the procedure (colonoscopy). Review of the end time of the upper endoscopy procedure and the beginning time of the colonoscopy procedure were not documented.

    Review of the Patients' records and interview with the Clinical Coordinator on 1/17/19 at 11:00 AM noted that the intraoperative record did not have a specific area to fill in and document the end time of the upper endoscopy or the start time of the colonoscopy. Further

interview identified that the information should be documented by the nurse in the note section of the intraoperative record.
The facility policy for documentation guidelines for nursing staff identified to maintain an accurate clinical patient record. The policy indicated that the documentation should be clear concise and specific.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (i) General (6).

14. *Based on clinical record reviews, review of policies and interviews with staff for 1 of 3 patients reviewed for procedures (Patient #50) the hospital failed to ensure that procedural equipment was not retained. The findings include:
    a. Patient #50 was admitted on 2/6/19 and underwent a hystosalpingogram which required the insertion of a catheter into the uterus followed by an injection of dye. At the conclusion of the procedure MD #7 was identified as removing the catheter and then left the room. Patient #7 went to the restroom and identified a plastic straw-like object in the vagina, removed it and handed it to the radiology technician. The item was noted to resemble a catheter sheath. Patient #50 was discharged with problems identified.
    Interview with MD #7 on 2/25/19 at 9:40 PM identified that she believed that she removed the catheter at the conclusion of the procedure but it must not have come out fully. When the patient stood up, it was recognized that the catheter was in the vagina and the patient removed it.
    Review of the hospital's Hystosalpingogram Protocol identified that there was no provision for the accounting of medical supplies and/or procedural items used during a hystosalpingogram.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1) and/or (i) General (3)

15. Based on clinical record review, interview and policy review the facility for 3 of 6 patients reviewed for restraint use, the facility failed to ensure that the patients were monitored while in restraints and/or that the restraints were removed at the earliest possible time. The findings include the following:
    a. Patient #13 was admitted on 1/13/19 with hypoxia and pneumonia. The clinical record indicated that on 1/16/19 the patient was agitated and at 5:15 PM, an order for violent restraints identified that the patient was a danger to self, danger to others and fall potential. The Nurse's note dated 1/16/19 at 5:44 PM indicated that the patient was agitated, hitting, scratching and spitting. The note indicated that the patient was placed in bilateral wrist restraints for staff safety and Haldol IM was given.
    b. Review of the record indicated that the patient was monitored every two hours by the RN. Review of the restraint continuous observation flow sheet indicated that the restraints were initiated at 5:30 PM on 1/16/19 and the patient was combative, yelling, cursing and verbally

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

threatening. The fifteen minute checks indicated that for the period of 11:15 PM through 5:00 AM on 1/17/19 the patient remained in restraints and the behaviors identified were disoriented, quiet, cooperative, talking to self, or sleeping. The period of 5:00 AM on 1/17/19 through 9:45 AM indicated that although the patient was sleeping he/she remained in restraints.

c. Interview with the Nurse Manager on 1/17/19 at 1:30 PM indicated that the facility has two types of restraints non-violent and violent and that patients are monitored every two hours regardless of the type of restraints.

d. Patient #10 was admitted on 1/14/19 with alcohol abuse. Review of the clinical record indicated that on 1/16/19 there was a physician order at 9:02 PM that directed 2 point nonviolent wrist restraints. The monitoring flow sheet indicated that the patient was monitored by the RN at 9:02 PM on 1/16/19 and 8:05 AM and 10:14 on 1/17/19 at which time the restraints were discontinued. The facility failed to ensure that every two hour nursing monitoring was completed.

Review of Patient #49's physician's orders dated 11/6/18 at 4:00 PM and 8:00 PM directed four point locked restraints. The patient was placed in restraints on 11/6/18 at approximately 4:00 PM. The record indicated that the patient was a danger to self and hit a staff member. The patient was placed in four point locked restraints. Review of the nursing documentation indicated that the RN monitored the patient every two hours, at 11:46 PM the patient was cooperative with care, and was in two point locked restraints. Review of Patient 49's restraint observation record for 11/6/18 at 4:00 PM indicated that the patient was in four point restraints. The fifteen minute checks indicated that the patient was combative and trying to hurt self. The fifteen monitoring indicated that on 11/6/18 at 6:00 PM through 10:15 PM the patient remained in four point restraints and the behaviors identified requiring four restraints were agitated and restless. For the period of 10:30 PM through 11:45 PM on 11/6/18 the fifteen minute checks indicated that the patient was quiet and cooperative however remained in four point restraints. The facility failed to ensure that restraints were discontinued at the earliest possible time.

The fifteen minute monitoring indicated that that for the period of 11:30 on 11/6/18 through 12:30 AM on 11/7/18 the patient's behaviors requiring restraints were identified as sleeping the patient was in 2 point restraints.

Review of Patient #49's physician's orders dated 11/7/18 at 1:56 PM directed the use of violent locked four point restraints. The RN monitoring flow sheet indicated that at 3:28 PM on 11/7/19 the patient was in four points with the clinical justification identified as "intervention ineffective". Review of the restraint observation record indicated that the patient was placed in four point locked restraints at 2:00 PM on 11/7/18 with the behaviors identified as combative and trying to hurt self. The monitoring indicated that at 4:00 PM through 5:15 PM on 11/7/18 the patient was still and quiet however remained in four point restraints.

Patient #49's physicians order dated 1/7/19 at 6:00 PM directed four point violent restraints. On 11/7/18 at 5:56 PM Patient #49's nursing documentation indicated that the patient was in 2 point locked restraints with the clinical justification identified as "intervention

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

ineffective".

Review of the monitoring flow sheet with the Quality Specialist indicated that for the period of 5:30 PM through 7:45 PM on 11/7/18 the patient was in two point restraints with the behaviors identified requiring the use of locked restraints was agitated, quiet, sleeping and verbally appropriate. The facility failed to ensure that restraints were discontinued at the earliest possible time. The record indicated that the restraints were removed at 7:38 PM on 11/7/18.

The policy indicated that for Violent restraints the orders are time limited and that the order must specify the type of restraint. The policy indicated that at a minimum a patient in restraints should be observed every two hours by the RN. The policy indicated that the patient is observed by the RN every two hours. The policy indicated that the use of restraints should be frequently evaluated and ended at the earliest possible time based on an assessment of the patient.

The below are violations of the State of Connecticut Public Health Code Section 19-13-D3 Short Term Hospitals, General and Special (a) Physical Plant (2) & (i) General (6).

16. Based on tour and documentation review on January 23rd and 24th 2019, the following items were observed:
    a. The surveyor was not provided with documentation from facility staff that would indicate that personnel that are conducting the required interval inspections and testing of the facility fire alarm system meet the requirements set forth by section 10.2.2.5.1 of NFPA 72.
    b. The surveyor was not provided with documentation from facility staff that would indicate that personnel that are conducting the required interval inspections and testing of the facility fire sprinkler system have a current State of Connecticut F-1 license.
    c. The surveyor, accompanied by facility staff, observed that the fire sprinkler heads behind the sterilizing machines within the Central Sterile Processing Department are incorrectly installed for that type of application and coverage area.
    d. The surveyor, accompanied by facility staff, observed that the Emergency Department Triage area lacks adequate exit signage, not meeting the requirements set forth by section 7.10.1.2.1 of NFPA 101.
    e. The surveyor, accompanied by facility staff, observed that Sub-sterile Rooms # 1&2 and 6&7 within the Operating Room suite have wall damage, rust stained flooring, and missing pieces of floor drain grating.
    f. The surveyor, accompanied by facility staff, observed that the "crisis bathroom" within the Emergency Department lacks tamper resistant fasteners, has a broken mirror, a suspended ceiling assembly, and contains utility fixtures that are not intended for use in a behavioral health unit environment.
    g. The surveyor, accompanied by facility staff, observed that the exhaust ductwork for the ETO sterilizing machine within the Central Sterile Processing Department is not constructed or installed to the standards set forth by section 510.8 of the International Mechanical Code.
    h. The surveyor, accompanied by facility staff, observed that the required fire wall for the main

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soiled linen storage room was incomplete i.e. missing blocks and large holes therefor not maintaining the required resistance to the passage of fire and smoke as required in NFPA101:

i. The surveyor, accompanied by facility staff, observed that the double corridor doors for the main soiled linen room was damaged and the doors were binding and not fully closing as required by NFPA 101, negating the assembly's ability to resist the passage of fire & smoke as required.

j. The surveyor, accompanied by facility staff observed that the corridor door for the main medical gas manifold room and storage area lacked a 1 hour rating plate not maintaining the 1 hour separation as required by NFPA 99 Heath Care Facilities and the room lacked the ventilation for the storage of gases greater than 3000 cubic feet as required by NFPA 99 Health Care Facility.

Bristol Hospital
1. DPH Plan of Correction-Action

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3(b) Administration (2) and or (c) Medical Staff (2) (B) and/or (i) general (6) **1(a)** **Responsible Leader:** Vice President Patient Care Services/CNO **Plan/System Improvement:** Review of Critical Lab Values-Physician Notification was completed.			
Professional Development Coordinator sent Critical Lab Values-Physician Notification Policy education (identifying all critical lab values need to be reported to physician) to all nursing staff via Health Stream, failure to complete education will result in the inability to work.	Professional Development Coordinator (PDC)	4/5/2019	Quality Improvement Committee of the Board (QICB) and Nurse Professional Practice Council (NPPC)
Audits for adherence to "Critical Values-Physician Notification" policy to be completed by the Quality Department for 100% compliance of the documentation consisting of communication from the Lab to the Registered Nurse and communication from the Registered Nurse to the Provider daily starting April 6, 2019. Lab will supply a daily report of critical values for inpatients over the previous 24 hours to the quality department. The quality department will match this with physician documentation. Audits for all critical results notifications for in-house	Quality Department	4/6/2019 and Ongoing	QICB and Hospitalist Oversight Committee (HOC)

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
patients for 100% compliance for 90 days. **1(b)** **Responsible Leader:** Vice President of Operations and Section Chief of Medicine **Plan/System Improvement:** Education to all hospitalists in regards to critical results defined by Bristol Hospital policy. Education done in reference to Medical Staff Rules and Regulations Section III Documentation, Subsection B. All hospitalists will document receipt of critical lab values regardless of initiating additional treatment in an event note in the EMR. Education started on March 19, 2019 via face to face meeting with Medical Director of Hospitalists. Read and sign education of the critical values policy will be completed by 100% of the hospitalists by April 5, 2019.	Vice President of Operations, Medical Section Chief of Medicine, Director of Hospitalists	4/5/2019	
Monitoring: Audits for all critical results notifications for in-house patients for 100% compliance for 90 days. This will begin April 6, 2019 will be conducted by the quality department.	Quality Department	4/6/2019 and ongoing	QICB monthly
1(c) **Responsible Leader:** Vice President of Operations and Section Chief Medicine **Plan/System Improvement:** Formal sign off process was developed for contracted services (Hospitalists) to conform to medical staff bylaws in regard to continuity of care. Process includes identifying of patients on the active roster that will require follow up. A report will be created daily that	Vice President Operations	4/12/2019	Hospitalist Oversight Committee (HOC)

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
will allow the oncoming hospitalist to review event notes from the prior hospitalists in regards to critical values and encounter documentation. **Implementation:** Education of new sign off procedure to begin March 25, 2019 with all hospitalist group. **Monitoring:** Quality Department will monitor daily sign off report and correlate with the critical values report starting April 15, 2019. **1(d)** **Responsible Leader:** Vice President of Operations and Section Chief of Medicine **Plan/System Improvement:** Implementation of a Hospitalist Oversight Committee, with members of Executive Leadership Group and Medical Director of Hospitalists Services, which will meet monthly. **Monitoring:** Weekly meeting will include: • staffing hospitalists per hospital census • evaluation of services compared with contracted services agreement	Medical Director Hospitalist Quality Department Vice President Operations VP Operations Medical Director of the Hospitalist	4/14/2019 4/15/2019 and ongoing 4/5/2019 3/22/2019 and ongoing	HOC and QICB Monthly ECMS, President of the Medical Staff and President/CEO HOC

Bristol Hospital
2. DPH Plan of Correction-Action

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3 (b) Administration (2) **2(a)** **Responsible Leader:** Vice President PCS/CNO The Quality Improvement Committee of the Board (QICB), that is the governing body responsible for the oversight of the Quality Assurance and Performance Improvement Initiatives at Bristol Hospital, will continue the integration of the Senior Behavioral Health Unit (SBHU) services and metrics into periodic reporting requirements. This will provide the necessary governing body oversight for these functions. These metrics will include the development and implementation of performance measures to include patient safety on the Senior Behavioral Health Unit.			
Plan/System Improvement: All falls, restraints, assaults, and adverse events are entered into RL Solutions by staff. The SBHU Leadership (Program and Medical Director) will review all incidents and provide updates on analysis and trends to staff at the monthly departmental meeting. The hospital based Falls Committee reviews all falls and falls with injury, for every unit and will use comparative Benchmark data from NDNQI. Meeting minutes will be submitted to Quality Improvement Committee of the Board monthly, for review. The SBHU quarterly Precursor report collates all risk events on the unit, identifying trends and high	Director of Inpatient Services	4/11/2019 and Ongoing	Falls Committee Quality Improvement Committee of the Board (QICB)

risk, high volume and/or high priority events for process improvement. Begin April 11, 2019			
Implementation: SBHU unit will enter all falls, restraints, assaults, and adverse events into RL Solutions by staff, analyze their causes, implement preventive actions and provide mechanisms that include feedback and learning throughout the hospital. Bristol Hospital will update the organizations QAPI policy "Performance Improvement, Quality Assurance, and Patient Safety Plan" to include patient safety measures specific to the Senior Behavioral Health Unit (SBHU). The following measures will be included: • Patient Falls and fall risk assessments • Use of restraint and seclusion • Assaults	Quality Department, SBHU Operations Manager or SBHU Program Director	3/22/2019 and Ongoing	QICB
Monitoring: SBHU will develop performance measures related to falls, use of restraints and seclusion, and assaults. These performance measures will be monitored, tracked, and analyzed monthly and reported monthly at QICB.	SBHU Operations Manager or Program Director	4/5/2019 and Ongoing	QICB
Falls will also be reported monthly at the falls committee. Beginning March 25, 2019	Chair of the Falls Committee	4/11/2019 and Ongoing	Falls Committee
Unit Leadership will disseminate the results of the performance measures to staff daily at unit safety huddles.	Department Leadership	4/5/2019 and Ongoing	Daily Unit Huddles
Performance measures will be disseminated monthly at Unit Council Meeting.	Department Leadership	4/23/19 and Ongoing	Unit Council Meetings

Bristol Hospital
3 – 4 DPH Plan of Correction-Action

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) (b) and/or (i) General (6) **3** **Responsible Leader:** Board of Directors, BHHCG **Plan/System Improvement:** The governing body, Board of Directors, will ensure the medical staff provides quality medical care to patients. Meeting to review RCA was held with Executive Leadership Group (ELG) in October 2018. Change in perioperative director leadership enacted on October 1, 2018. OR/ASU time out procedure and policy was reviewed. Time Out Task Force was created on October 29, 2018 to revise the Time Out Procedure, after review of real time audits identified that the scripting seemed to become "white noise" and staff engagement was lacking. Also, the procedure for moving a patient from the ambulatory surgery area to the operating room needed standardization. Handoff communications from RN to RN were hardwired with an audit tool to evaluate 100% of handoff success. The Task Force that was created includes nursing leadership, anesthesiology, surgeons, nursing staff, professional development, and quality department. This task force phoned and visited other facilities to discuss and observe best practices. Nurse leaders and physicians conducted literature searches for best practices from professional organizations and shared the feedback at the Task Force Committee meeting.	Director of Perioperative Services Director of Perioperative Services	10/15/2018 10/29/2018 and Ongoing	Executive Surgical Peri-Op Oversight Committee (ESPOC) monthly Quality Improvement Committee of the Board (QICB) monthly

The committee established recommendation for scripting with the new process flow and safety initiatives for time out practices. **3(a)** **Implementation:** Specific Injection sites are now marked in pre-operative area prior to entering procedure room, not just for laterality as was the prior practice. Education was provided to surgeons and anesthesiologists via high alert email to Surgeons, Nurses, and Anesthesia, highlighting the deviations from best practice. Site visits to other hospitals to observe best practices as well as a consultant (Dr. Bloomstone) was hired to assess current practices, review wrong site surgeries and provide education and recommendations.	Director of Perioperative Services	10/19/2018	ESPOC
Monitoring: Audits involving the actual injection site marking are continuing to be done as (self-reported on October 25, 2018), DPH CAP 0041-18-05 and TJC CAP 313239 state. These audits of procedure began on October 22, 2018, and we have been 100% compliant. The audit is completed on every scheduled patient requiring a pain injection in ASU, identifying that the actual injection site is marked prior to leaving the holding area.	Director of Perioperative Services	10/22/2018 and Ongoing	ESPOC and QICB monthly
3(b) **Implementation:** Time out procedure audits of all scheduled elective operative procedures with an emphasis on laterality, active participation and engagement of staff continue. Audits of active participation and adherence to current time out procedure continue to be done, as (self-reported September 21, 2018), DPH CAP 0041-18-04 and TJC CAP 309909 state.	Director of Perioperative Services	9/21/2018 and ongoing	ESPOC and QICB Monthly

Monitoring: These audits of the adherence to our time out procedure began on September 21, 2018, and have been over 97% compliant since October 12, 2018, and 100% complaint since November 5, 2018. This is an audit that ensures everyone stops to participate in the timeout process. The audit is done in real time, on scheduled elective procedures with an emphasis on laterality, active participation and engagement of staff.	Director of Perioperative Services	9/21/2018 and ongoing	ESPOC and QICB Monthly
3(c) **Implementation:** A meeting was held with the Administrative Director of Radiology Services, Manager of Patient Access, Quality Department and staff involved, which determined there was a breakdown in scheduling process for injections performed in Interventional radiology. Going forward, paper copies of the physician's orders will be required prior to the procedure.	Director of Diagnostic Imaging	4/17/2018	
Monitoring: Audits of the scheduling procedure where the paper order from an outside physician matches the scheduled procedure placed by the scheduler have been completed per (Self-Reported on April 19, 2018) DPH CAP 0041-18-03. These audits began on April 18, 2018 and continued for 90 days of 100% compliance. 5 audits were done daily, not just for injections, but for all scheduled procedures.	Manager of Patient Access	DPH Audits completed 8/27/2018	QICB monthly
Under that same self-reported corrective action plan, Diagnostic Imaging had been auditing all procedures scheduled as "Injection" by confirming that the paper order sent by the primary care office stated "Injection". Audit process of scheduled "Injection" procedures by Diagnostic Imaging staff matching scheduled procedure to the order from the primary care office began April 18, 2018 and continued for 90	Director of Diagnostic Imaging	DPH Audits completed 8/28/2018	QICB monthly

days for 100% compliance. **Section 19-13-D3 (c) Medical Staff (2) (B)** **4** **Responsible Person:** Board of Directors, BHHCG **Plan/System Improvement:** The Physician's documentation error was submitted to Medical Peer Review Committee for emphasis on ensuring medical staff bylaws are followed for documentation. Since this wrong side surgical procedure resulted in (self-reported on September 21, 2018) DPH CAP 0041-18-04 and TJC CAP 309909, Audits have continued involving adherence to the time out procedure which involves reviewing an accurate consent associated with a procedure. These audits of the adherence to our time out procedure began on September 21, 2018, and have been over 97% compliant since October 12, 2018, and 100% complaint since November 5, 2018. **Implementation:** **4(a)** Surgeons note was amended on March 20, 2019. Case will be forwarded for second Medical Peer Review (March 28, 2019) for failure to amend the operative note with the correct documentation. **4(b)** No Time written on Consent for cortisone injection: Case sent to medical peer review for lack of documentation. Physician to be re-educated on informed consent policy and the Medical Staff Bylaws via Read and Sign documentation.	The President of Medical Staff Director of Perioperative Services President of the Medical Staff President of the Medical Staff President of the Medical Staff	3/28/2019 9/21/2018 and Ongoing 3/28/2019 3/28/2019 3/28/2019	Peer Review ECMS Audits Reported to: QICB monthly ECMS ECMS ECMS

4(c) **Implementation:** March 20, 2019 addendum was added to the record to reflect cortisone injection procedure. Case sent to medical peer review for lack of documentation	President of the Medical Staff	3/28/2019	ECMS
Monitoring: Any new cases of wrong site surgery or lack of documentation will be entered into the electronic incident monitoring system and investigated. Any new cases of wrong site surgery or documentation will also be forwarded to Medical Peer Review.	Quality Department	3/28/2019	Medical Peer Review

Bristol Hospital
5-6 DPH Plan of Correction-Action

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3 (e) Nursing Services (1) and/or (i) General (6)			
5(a) **Plan/System Improvement:** Fall policy, 1:1 policy and Restraint and Seclusion policy reviewed on January 22, 2019, no revisions were necessary.	Vice President of Patient Care Services/CNO, Director of Horizon and Quality Manager.	1/22/2019	Reviewed at Daily Unit Safety Huddle (Senior Behavioral Health Unit) by the Clinical Coordinator.
Professional development designed a seclusion algorithm (Agitated Patient Decision Tree) for use during education to help guide staff through the utilization of restraint and seclusion usage for the geri-psych patients.	Professional Development Coordinator (PDC)		Quality Improvement Committee of the Board (QICB)
Education for the Senior Behavioral Health Nursing Staff began on March 18, 2019 using the new "Agitated Patient Decision Tree", that will be added to the restraint and seclusion policy, as an adjunct to maximizing a patient's safety and promoting their wellness in an agitated state. This specific event was identified and self-reported to the Department of Public Health (DPH CAP 0041-19-03).	PDCs	4/05/2019	Fall Committee
Alternative Measures Usage Audit Tool has been developed to monitor for the documented use of alternative measures prior to the use of restraints/seclusion on all in patient units and the ED. Audits will be conducted for 100% compliance for 90 consecutive days.	Director of Inpatient Services	4/05/2019 and Ongoing	QICB

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Fall Prevention and Constant Observation Policy reeducation for all nursing staff and patient care associates will begin March 21, 2019 Track and Trend (Falls, RLs, Adverse Events including Restraint and Seclusion and other items as identified by Units Leadership) and present data on a monthly basis to QICB Committee and Hospital Falls Committee	Program Director SBHU SBHU Operations Manager	4/05/2019	QICB and Falls Committee
5(b) Fall Prevention Policy reviewed and reeducation for all nursing staff and patient care associates will begin March 21, 2019.	PDC	4/05/2019	QICB Monthly
Every patient fall within the hospital, per policy, requires a post fall huddle assessment. Each huddle assessment will be reviewed by unit operations manager and forwarded to the falls committee for review monthly.	Director of Inpatient Services	4/05/2019 and Ongoing	QICB Monthly
Implementation: Education on the use "Agitated Patient Decision Tree" sent electronically as mandatory nursing competency for the Senior Behavioral Health Unit Nursing Staff on March 18, 2019.	PDCs	4/05/2019	
Fall Prevention Policy Education sent out via HealthStream, beginning March 21, 2019.	PDC's	4/05/2019	
Monitoring: "Agitated Patient Decision Tree" education completion monitored by Professional Development Coordinator for 100% completion. Fall prevention Policy Reeducation to be monitored by Professional Development Coordinator along with Operations Managers of each floor for 100% completion. Failure to complete re-education results in	PDC & Operations Manager	Education Ends: 4/05/2019	Falls Committee & Quality Improvement Committee of the Board (QICB)

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
inability to work. Patient Falls Continue to be monitored, tracked and analyzed, monthly, through our falls and reported will be reported monthly at QICB.	Director of Inpatient Services	4/06/2019 and Ongoing	QICB
6(a) **Responsible Person:** Vice President of Patient Care Services/CNO			
Plan/System Improvement: Education provided to all nursing staff including patient care associates on the Constant Observation Policy, which discusses patient behaviors with emphasis on documentation of specific behaviors warranting constant observation.	PDC		
Implementation: Education on constant observation policy provided to all nursing staff including patient care associates via HealthStream, beginning on March 21, 2019.	PDC	4/05/2019	
Monitoring: Operation Managers to monitor education completion reports of staff via HealthStream daily for 100% completion. Failure to complete re-education results in inability to work. Staff on leave will be required to complete Health Stream education before being able to accept a patient assignment. Audits of compliance to the Constant Observation policy will be conducted by the Inpatient and Emergency Center Operations Managers for 95% compliance for 90 days.	Operations Managers	4/05/2019	QICB

Bristol Hospital
7/8 DPH Plan of Correction-Action

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3 (e) Nursing Services (1) and/or (i) General (6) **7** **Responsible Leader:** Vice President PCS/ CNO			
Plan/System Improvement: The Vice President Patient Care Services/CNO and Quality Manager reviewed the policy for Medication Administration and Pain Assessment. Revisions were not required at this time.	Vice President PCS/ CNO	3/19/2019	
All nursing staff will receive mandatory education on the "Medication Administration Policy" and "Pain Assessment Policy" whereby facilitating the accurate administration and charting of medications to patients. All nursing staff will administer medications to patients per policy and physician order.	Professional Development Coordinator	4/05/2019	
Implementation: Pain Management assessment and reassessment documentation reminder will be an agenda item at hospital wide for one week and unit based safety huddles for 30 days.	Unit Based Operations Managers - Quality	4/25/2019	Safety Huddles
Mandatory Education on Pain Assessment documentation, administering pain medication, orders with parameters, and wasting controlled substances, will be provided via Health Stream to all staff nurses.	Director of Inpatient Services	4/05/2019	Quality Improvement Committee of the Board (QICB)

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Monitoring: Education will begin March 25, 2019, Operations Managers will monitor for completion of education to ensure all staff have completed the training prior to April 5, 2019. Staff on leave will receive training immediately upon return from leave and prior to receiving a patient care assignment.	Director of Inpatient Services	4/05/2019	
Audits of pain medication administration per order will be conducted by Inpatient Operations Managers and Emergency Center Operations Managers. These managers will audit 10 pain medication administrations per week for 30 days. If 95% compliance is sustained than audits will continue with 10 pain medication administrations per month for 90 days. Audits to begin April 6, 2019.	Director of Inpatient Services	4/06/2019 and Ongoing	QICB and Nursing Professional Practice Council (NPPC).
Results of audits will be reviewed in daily unit safety huddles and just-in-time training will be provided.	Director of Inpatient Services	4/06/2019 and Ongoing	
Audits of pain score reassessments to be done by Inpatient and Emergency Center Operations Managers. Audits to begin April, 6, 2019. Inpatient and Emergency Center Operations Managers will audit 10 medication administrations per week for 30 days. If 95% compliance is sustained than audits will continue with 10 medication administrations per month for 90 days. Results of audits will be reviewed in daily unit safety huddles and just-in-time training will be provided.	Director of Inpatient Services	4/06/2019 and Ongoing	QICB and NPPC

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
8 **Responsible Leader:** Vice President PCS/ CNO **Plan/System Improvement:** The Vice President Patient Care Services/CNO and Quality Manager reviewed the policy for Medication Administration and Pain Assessment. Revisions were not required at this time.			
All nursing staff will receive mandatory education on the "Medication Administration Policy" where by facilitating the accurate administration and charting of medications to patients. All nursing staff will administer medications to patients per policy and physician order. All nursing staff will receive mandatory education on the "Medication Administration Policy" and "Pain Assessment Policy" whereby facilitating the accurate administration and charting of medications to patients. All nursing staff will administer medications to patients per policy and physician order.	Professional Development Coordinators (PDC)	4/05/2019	QICB
Implementation: Education will begin March 21, 2019. Operations Managers will monitor for completion of education to ensure all staff have completed the training. Staff that are on leave will receive training immediately upon return from leave and prior to receiving a patient care assignment.	Director of Inpatient Services	4/05/2019	
Monitoring: Narcotic audits will be conducted by Inpatient Unit and Emergency Center Operations Managers. All audits to be sent to Director of Pharmacy for secondary review.	Director of Inpatient services		Pharmacy and Therapeutics Committee

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Pharmacy will run daily reports for discrepancies, undocumented controlled substance waste, and overrides. This will be reviewed and reported out at monthly at Pharmacy and Therapeutics Committee. On a monthly basis, Chief Nursing Officer will receive and review committee minutes.	Director of Pharmacy	4/06/2019 an Ongoing	P&T
1. A standardized audit tool will be developed which will include: • Order for the medication • Medication administered corresponds with order frequency. • Medication administration is properly documented in the EMR • Pain level corresponds with the medication amount • Did medication require a waste? • Was the waste witnessed if applicable?	Unit Operations Managers	4/06/2019 and Ongoing	NPPC P&T QICB
2. A narcotics administration audit will be conducted. Ten separate nurse narcotic administrations will be audited weekly on each inpatient unit and the Emergency department.	Unit Operations Managers	4/06/2019 and Ongoing	P&T QICB
The pharmacy will conduct routine monitoring to assess for trends that have the potential for drug diversion. Identified trends are reviewed and submitted to the unit manager for further investigation.	Director of Pharmacy	4/06/2019 and Ongoing	P&T and QICB
Pharmacy will print reports daily for the next 30 days to monitor for narcotics wasted without a second person verifying the waste, for all inpatient units and the emergency department.	Director of Pharmacy	3/25/2019 and Ongoing	P&T

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Any records that are identified with narcotic wastes without a second verifier will be audited for investigation of diversion and the unit supervisor will be notified to provide additional education to the staff. If after 30 days there are no discrepancies, these same audits will be conducted weekly for 30 days and then monthly thereafter. Data collection will be analyzed and reported at the monthly Pharmacy and Therapeutics Committee.			

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Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (4) (A) and/or (e) Nursing Services (1) and/or (f) Diagnostic and Therapeutic facilities and/or (i) General (6) and/or (1) Infection Control (1) (A) **9(a)** **Responsible Leader:** Director of Peri-Operative Services			
Plan/System Improvement The Director of Peri-Operative Services and Quality Manager reviewed the policy for operating room attire. Revisions were not required at this time.	Director of Peri-Operative Services	5/01/2019	
Implementation All Peri-Operative Staff will receive mandatory education on "Operating Room Attire" Policy/Procedure with a focus on subsection 3 – "Hats and Masks"	Professional Development Coordinator (PDC)	5/20/2019	Quality Improvement Committee of the Board (QICB)
Monitoring Mandatory Education on "Operating Room Attire" policy will be provided via read and sign via policy manager to all Peri-Operative staff.			
Education will begin May 8, 2019. Operations Manager will monitor the completion of the education prior to May 20, 2019.	Director of Peri-Operative Services	5/20/2019	QICB
Audits will be part of the environmental rounds with infection preventionist.	Infection Prevention Manager	Ongoing	Safety Committee

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
9(b) **Responsible Leader:** Systems Director, Support Services			
Plan/System Improvement The Systems Director, Support Services and Quality Manager reviewed the procedure for operating room terminal cleaning. Revisions were not required at this time.	Systems Director, Support Services	5/02/2019	
Implementation All General Services Attendants (GSA's) will receive mandatory education on "Operating Room Terminal Cleaning" procedure.	Systems Director, Support Services	5/28/2019	
Monitoring Mandatory Education on "Operating Room Terminal Cleaning" procedure will be provided via a terminal cleaning simulation class to all GSA's. Education will be completed by May 28, 2019.	Systems Director, Support Services		
Environmental Services Manager will monitor the completion of the education.		5/28/2019	Infection Prevention
Audits will be done on terminal cleaning in the OR by General Services Leadership for 90 days of 100% compliance.		8/25/2019	Committee
10(a) **Responsible Leader:** Medical Director, Laboratory			
Plan/System Improvement "Accu-Chek Inform II System Glucose Testing" policy reviewed, revisions were not required at this time.	Medical Director, Laboratory		
Implementation Education via email to all Nurses and techs about the importance of dating the control bottles when opened (per policy) and to	PDC's	5/24/2019	Lab Quality Assurance Meeting

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
ensure that the date is not smudged will begin on 5/10/2019.			
Monitoring Weekly audits will be done by Point of Care Coordinator of 10 meters and the associated solutions expiration dates. This will be done until 100% compliance is met for 90 days.	Medical Director, Laboratory	8/25/2019	Lab Quality Assurance Meeting
Audit Sheets will be sent to the Quality Department for review and will follow up with any non-compliance of the policy.	Quality Department	8/25/2019	QICB
11(a) **Responsible Leader** Systems Director, Support Services			
Plan/System Improvement Review of manufacturer's recommendations for the Olympus Endoscope Reprocessor identified that monthly maintenance requires change of water filters. Review with Systems Director, Support Services indicates water filters changed but not documented.	Systems Director, Support Services	Ongoing	Safety Committee Meeting
Implementation Water filter maintenance log has been implemented as of April 10, 2019. Log is updated monthly with date of water filter changes. This has also been added as a monthly task in our automated maintenance system.	Systems Director, Support Services	Ongoing	Safety Committee Meeting
Monitoring Audits will be done by the lead tech weekly beginning May 6, 2019	Systems Director, Support Services	Ongoing	Safety Committee Meeting

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
12(a) **Responsible Leader** Administrative Director, Diagnostic Imaging			
Plan/System Improvement Any damaged equipment will be taken out of services including vinyl pads.	Administrative Director, Diagnostic Imaging	1/17/2019	
Implementation All damaged vinyl pads will be taken out of service as soon as identified. Discussion item at daily department safety huddles starting on May 13, 2019	Administrative Director, Diagnostic Imaging	Ongoing	Daily at Unit Safety Huddles
Monitoring Diagnostic Imaging Department will continue to remove broken/damaged equipment from services.		Ongoing	
12(b) **Responsible Leader** Administrative Director, Diagnostic Imaging			
Plan/System Improvement Re-education done with lead tech in regards to job description stating responsibility of maintaining adequate inventory of all required supplies.	Administrative Director, Diagnostic Imaging	1/17/2019	
Re-education also done with lead tech regarding the policy on "General Storage Areas" with a focus on shelf control being the responsibility of the department.		1/17/2019	
Implementation All expired stents and wires in the IR closet were removed on January 17, 2019.		1/17/2019	

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Monitoring Diagnostic Imaging Lead Tech will maintain supplies per policy and job description by weekly monitoring of product inventory expiration dates.	Administrative Director, Diagnostic Imaging	Ongoing	
Random monthly audits of compliance will be done by Diagnostic Imaging Leadership. Audits will continue for 90 days of 100% compliance beginning May 13, 2019.	Administrative Director, Diagnostic Imaging	8/12/2019 and Ongoing	Diagnostic Imaging Leadership Meeting

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Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3 (b)Administration (2) and/or (c) Medical Staff (4) (A) and/or (d) Medical Records (3) and/or (e) Nursing Services (1) and or (i) General **13** **Responsible Person** Director of Peri-Operative Services **Plan/System Improvement** Review of documentation for dual scope procedures revealed start/stop of endoscopy and start/stop for colonoscopy were not documented accurately. The operative record has the availability to document start/stop times of each procedure.	Director of Peri-Operative Services		
Implementation Education to all Endo staff on documentation of the dual scope procedures was done by Peri-Operative leadership on January 22, 2019.	Director of Peri-Operative Services	1/22/2019	Endo staff meeting
Monitoring Audits for adherence to documentation of start/stop endoscopy – start/stop colonoscopy will be done by Manager of ASU/Endo starting May 13, 2019. All scheduled dual scope procedures will be audited for 100% compliance in documentation for 90 consecutive days.	Director of Peri-Operative Services	8/11/2019	Endo staff meeting

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DPH 14 Plan of Correction-Action

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (4) and/or (l) General **14** **Responsible Person** Chair of Department of OB GYN **Plan/System Improvement** Case sent to Medical and OB GYN peer review. OB GYN peer review recommends that all instruments removed at the end of a Hysterosalpingogram (HSG) procedure in radiology and documented. **Implementation** Starting May 6, 2019 physicians will document all instruments removed at the end of all HSG procedures done in Diagnostic Imaging. **Monitoring** Starting May 6, 2019 Quality Department will audit for documentation of all instruments being removed post HSG for all cases for 100% compliance for 90 days.	Chair of Department of OB GYN Chair of Department of OB GYN Quality Department	4/03/2019 8/04/2019	Quality Improvement Committee of the Board

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Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (4) and/or (i) General **14** **Responsible Person** Chair of Department of OB GYN **Plan/System Improvement** Case sent to Medical and OB GYN peer review. OB GYN peer review recommends that all instruments removed at the end of a Hysterosalpingogram (HSG) procedure in radiology and documented. **Implementation** Starting May 6, 2019 physicians will document all instruments removed at the end of all HSG procedures done in Diagnostic Imaging. **Monitoring** Starting May 6, 2019 Quality Department will audit for documentation of all instruments being removed post HSG for all cases for 100% compliance for 90 days.	Chair of Department of OB GYN Chair of Department of OB GYN Quality Department	4/03/2019 8/04/2019	Quality Improvement Committee of the Board

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DPH 15 Plan of Correction-Action

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3 (b) Administration and/or (i) General **15** **Responsible Person** Vice President Patient Care Services, Chief Nursing Officer **Plan/System Improvement** A review of the restraint logs and restraint audit tools revealed that they were not consistent throughout the organization. A standardized restraint log and audit tool was created to conform to the current policy. An audit tool will be used each time a patient is placed in restraints. The audit tool includes: • Continuous observation flow sheet completed and behavior codes congruent with nursing documentation • Nursing documentation indicating patient condition supporting discontinuation of restraints and time that restraints were removed. • Nursing documentation under "restraint flow sheet" on nursing work list every 2 hours (at minimum) for patients in restraints. **Implementation** The standardized restraint log, audit tool and policy will go to Nurse Professional Practice Council (NPPC) on May 16, 2019 for review. Education to be done by May 31, 2019.	Director of Inpatient Services Operations Manager – G Level	5/08/2019 5/31/2019	Nursing Leadership Meeting NPPC

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Monitoring Starting June 1, 2019, weekly restraint log compliance will be monitored by the Operations Manager ensuring restraints are utilized and documented according to policy and provider orders.	Director of Inpatient Services	Ongoing	Nursing Leadership Meeting

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DPH 16 Plan of Correction-Action

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Section 19-13-D3 Short Term Hospitals, General and Special (a) Physical Plant (2) & (i) General			
16(a) **Responsible Person** Systems Director, Support Services			
Plan/System Improvement PSL Engineering trained 8 facilities employees to perform fire alarm/drill testing. The testing is now being performed as required.	Systems Director, Support Services	Complete 3/13/2019	Safety Committee
Implementation Training completed on March 13, 2019		Complete 3/13/2019	
Monitoring Spreadsheet has been developed to monitor fire alarm testing schedule.	Systems Director, Support Services	Ongoing	Safety Committee
16(b) **Responsible Person** Systems Director, Support Services			
Plan/System Improvement F1 License required testing will be outsourced and scheduled on a quarterly basis.	Systems Director, Support Services	5/09/2019 and ongoing	

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Implementation Johnson Controls will visit May 9, 2019 to set up required testing of the sprinkler system on May 31, 2019 and future quarterly testing.	Systems Director, Support Services	5/31/2019 and ongoing	Safety Committee
Monitoring Spreadsheet has been developed to monitor testing schedule.	Systems Director, Support Services	Ongoing	Safety Committee
16(c) **Responsible Person** Systems Director, Support Services			
Plan/System Improvement Sprinkler modifications were performed and completed on April 30, 2019 by outsourced company, Red Hawk.	Systems Director, Support Services	Completed 4/30/2019	Safety Committee
Implementation Completed.			
Monitoring No further action			
16(d) **Responsible Person** Systems Director, Support Services			
Plan/System Improvement Exit signage was installed on January 23, 2019	Systems Director, Support Services	Complete 1/23/2019	Safety Committee
Implementation Exit signage was installed.			
Monitoring No further action required.			

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
16(e) **Responsible Person** Systems Director, Support Services **Plan/System Improvement** Operating room walls repaired on May 2, 2019 by in house staff. Operating Room floor and drain repaired May 6, 2019 by Executive Tile and Flooring, LLC. **Implementation** Complete **Monitoring** No further action	Systems Director, Support Services	Complete 5/02/2019 Complete 5/06/2019	Safety Committee
16(f) **Responsible Person** Systems Director, Support Services **Plan/System Improvement** Crisis bathroom no longer in existence due to construction in Emergency Center. Removed on March 28, 2019. **Implementation** Complete **Monitoring** No further action	Systems Director, Support Services	Complete 3/28/2019	Safety Committee
16(g) **Responsible Person** Systems Director, Support Services **Plan/System Improvement** Quote and Purchase order for duct work for ETO sterilizing machine in CSS completed on May 6, 2019.	Systems Director Support Services	Complete 5/06/2019	

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
Implementation Duct work for ETO sterilizing machine in CSS to be replaced by June 4, 2019 **Monitoring** Monitor for completion. **16(h)** **Responsible Person** Systems Director, Support Services **Plan/System Improvement** Fire wall repair for linen storage area was repaired on February 1, 2019 **Implementation** Complete **Monitoring** No further actions required. **16(i)** **Responsible Person** Systems Director, Support Services **Plan/System Improvement** Double doors entering into linen storage area were found not latched. Double door now positively latches and has signage placed stating to keep doors closed at all times. **Implementation** Signage completed by May 6, 2019 **Monitoring** Complete	Systems Director, Support Services Systems Director, Support Services Systems Director, Support Services	6/04/2019 Complete 2/01/2019 Complete 5/06/2019	Safety Committee Safety Committee Safety Committee

Defined Measures to Prevent Reoccurrence	Responsible person	Completion Date	Where reported
16(j) **Responsible Person** Systems Director, Support Services **Plan/System Improvement** Main medical gas storage room lacked one hour rating plate and ventilation for the storage of gases >3000 square feet. Repairs completed to medical gas storage area. **Implementation** Vent has been added on February 2, 2019. Repair of plate and wall complete on May 2, 2019 **Monitoring** Complete	Systems Director, Support Services Systems Director, Support Services	Complete 2/02/2019 Complete 2/02/2019	Safety Committee Safety Committee